Stop & Check: Reducing Specimen Labeling Errors

Megan A. McGonagle ADN, RN
Lehigh Valley Health Network, Megan.McGonagle@lvhn.org

Faith Sisson ADN, RN
Lehigh Valley Health Network, Faith.Sisson@lvhn.org

Published In/Presented At

McGonagle, M. Sisson, F. (2019, Sept 26). *Stop & Check: Reducing Specimen Labeling Errors.* Poster Presented at: LVHN Vizient/ AACN Nurse Residency Program Graduation, Lehigh Valley Health Network, Allentown, PA.

Stop & Check: Reducing Specimen Labeling Errors

Meg McGonagle, ADN, RN & Faith Sisson, ADN, RN
RHCM
Lehigh Valley Health Network, Allentown, Pennsylvania

BACKGROUND

- Increased rate of preanalytical lab errors made by RN & TP on RHCM.
- Majority of errors involve identifying, labeling, and specimen handling.
- Specimen labeling errors threaten patient safety, are costly, and negatively effect patient satisfaction.
- Opportunity to create interventions that prevent lab errors and increase patient safety.

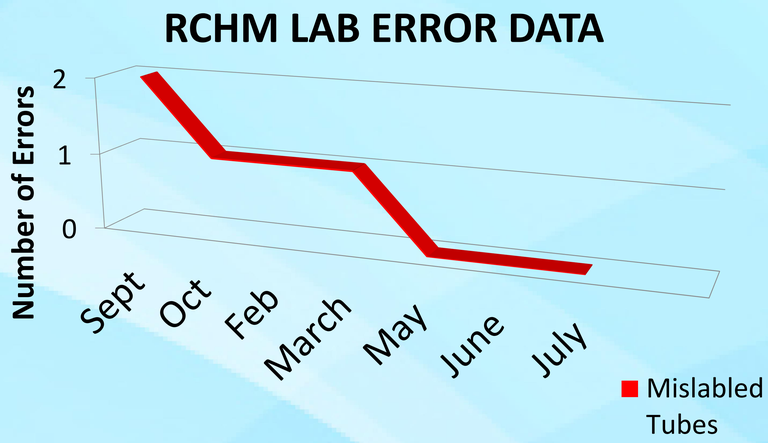
P I C O

- **P RNs & TPs who obtain labs on RHCM.**
- **I Visual prompts at tube stations (stop & check).**
- **C Current practice vs. visual prompts.**
- **O Preanalytical lab errors, increased patient safety and satisfaction.**

EVIDENCE

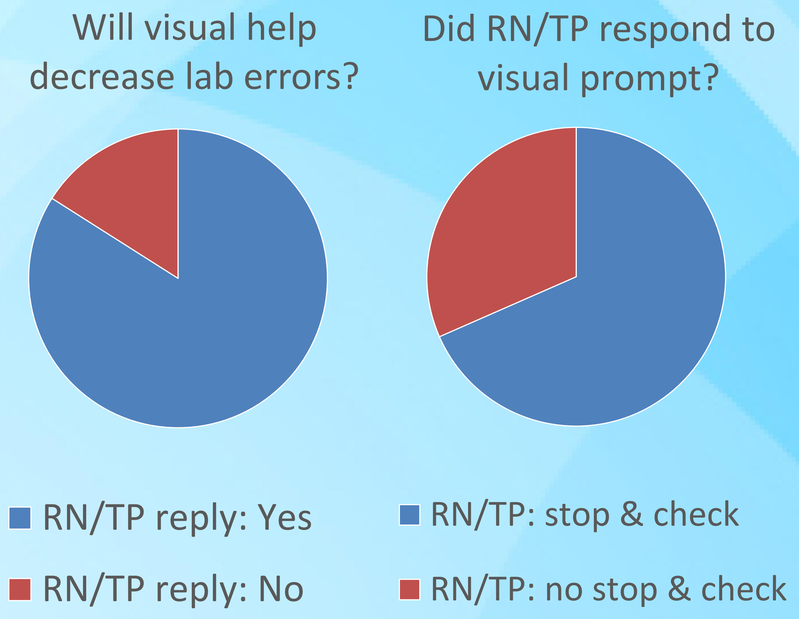
- Pre-analytical errors account for up to 70% of all mistakes made in laboratory diagnostics (Plebani & Carro, 1997).
- Mislabeled laboratory specimens can result in adverse patient outcomes (Wagar et al., 2006).
- Process-driven patient identification/specimen labeling protocols, including a low-cost crucial double check, reduces the frequency of specimen labeling incidents (Kim et al., 2013).
- The double check process reinforces a culture of safety in which processes improve and errors decrease (Kim et al., 2013).

OUTCOMES



Data reflects decrease in mislabeled lab specimens since April 2019

Survey results



IMPLEMENTATON

- Obtain lab error data from previous two quarters pre implementation.
- Survey RNs & TPs regarding perception of lab errors and if they thought a stop & check intervention would help reduce lab errors.
- April 2019 – Place large stop signs at tube stations.
- Post interventions (4-8 weeks later), obtain lab error data and compare.
- Resurvey RN/TP to evaluate if stop & check intervention created an opportunity to double check accuracy of laboratory specimens.

NEXT STEPS

- Educate staff on lab collection policies & procedures.
- Change signage quarterly to increase noticeability.
- Encourage collaborative efforts to reduce lab errors.
- Maintain culture of safety.

REFERENCES

- Metcalfe, M.H. & Whichello, R. (2015). Specimen labeling errors: a retrospective study. *Online Journal of Nursing Informatics*, *19*(2), 1-7
- Plebani M, & Carraro, P. (1997). Mistakes in a stat laboratory: Types and frequency. *Clin Chem*, *43*, 1348-1351.
- Wagar, E.A., Tamashiro, L., Yasin, B., Hilborne, L., & Bruckner, D.A. (2006). Patient safety in the clinical laboratory: a longitudinal analysis of specimen identification errors. *Archives of Pathology & Laboratory Medicine*, *130*, 1662-1668.
- Kohn, L. T., Corrigan, J., & Donaldson, M. S. (2000). *To err is human: Building a safer health system*. Washington, D.C: National Academy Press.
- Kim, J.K., Dotson, B., Thomas, S., & Nelson, K.C. (2013). Standardized patient identification and specimen labeling: a retrospective analysis on improving patient safety. *J Am Acad Dermatol.*, *68*, 53-56

Lehigh Valley Health Network

LVHN.org